DEPARTMENT OF HEALTH AND FAMILY SERVICES
Division of Health Care Financing
HCF 1151 (10/2000)

STATE OF WISCONSIN

MEDICAID PERSONAL CARE WORKER WEEKLY RECORD OF CARE

(single recipient with one or more funding sources)

Optional Form

1 **PATIENT NAME** Sally Smith

3

2 **EMPLOYEE NAME** Sue Jones **YEAR** 2000

4 **RECIPIENT IDENTIFYING NUMBER** 555555555

5	SUN	MON	TUES	WED	THUR	FRI	SAT
DATE OF SERVICE	/	1/12	/	1/14	/	1/16	/
6 **START TIME**		9 AM		9 AM		9 AM	
END TIME		5 PM		5 PM		5 PM	
7							
8 **ADL TASKS**							
Bathing		✓				✓	
Shower							
Hair Care/Shampoo		✓				✓	
Oral Care		✓		✓		✓	
Skin Care		✓		✓		✓	
Nail Care		✓		✓		✓	
Dressing/Undressing		✓		✓		✓	
Teds							
Splints/Braces (apply/remove)							
ROM							
Eye Glasses/Hearing Aid Care		✓		✓		✓	
Cath Care							
Transfers		✓		✓		✓	
Toileting		✓		✓		✓	
Bowel Program							
Vital Signs							
Medications							
Dressings							
Medical Appointments							
Feed Breakfast							
Feed Lunch							
Feed Supper							
Housekeeping							
Meal Prep		✓				✓	
Bed (change/make)				✓			
Light Cleaning							
Laundry							
Food Shopping							
9 **TOTAL MEDICAID TIME**		2 hrs.		1 hr.		2 hrs.	

10 **RECIPIENT SIGNATURE**

I verify this record is **accurate.**

Sally Smith — 1/16/2000

SIGNATURE - Recipient — Date signed

(11) COMMENTS

Always document reason(s) for changes in the time it takes to provide care. Date and initial all notations.

1-4-2000 Recipient refused bath today because family was visiting. - SJ.

1-6-2000 For lunch, prepared only soup for recipient due to small appetite. - SJ.

Note the following:

- General comments.
- Changes in recipient's condition.
- Emergency hours.
- Refusal of care.
- Institutional admission or discharge, including time of admission or discharge and time of cares given. (Example: Hospital admission on 12/4/99 at 2 p.m., cares given 9 a.m. to 1:30 p.m. Hospital discharge 2/14/99 at 5 p.m.)

(12) TRAVEL TIME

☒ Check this box if using computer-generated itinerary for travel time.
Complete the chart if deviating from routine itinerary or if not using computer-generated itinerary.

Date (MM/DD)	Travel TO Client				Travel FROM Client				Daily Total (rounded minutes)
	From Where	Time Begin	Time End	Total Time	Time Begin	Time End	Time Total	To Where	
Sun. /									
Mon. /									
Tues. /									
Wed. 01/04	office	8:45 am	9 am	15 MIN	5 pm	5:10 pm	10 MIN	Home	30 MIN
Thurs. /									
Fri. /									
Sat. /									

(13) PERSONAL CARE WORKER SIGNATURE

I verify that both pages of this record are **accurate** and **complete.**

Sue Jones — 1/6/2000

SIGNATURE - Personal Care Worker — Date signed

(14) RN SUPERVISOR SIGNATURE

Kathy Brown, RN — 1/7/2000

SIGNATURE - RN Supervisor and Title — Date signed